ORDERED that copies of this letter be transmitted to AUSA and defendants counsel.

USDJ

cc M. Makon

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U.S. DISTRICT COURT
OCT 26 2005
BROOKLYN OFFICE

03-CR-1378 (ARR)
10-24-05 D/F
Devon Malcolm
T06-34-053

Your Honor,

I would simply appreciate the chance of explaining what I am currently enduring been incorcerate at Metropoliton Detention Center.

I compleat Three previous operation the most recently was the Bronchoscopy, left Thoracotomy esophageal ditation which Rupture the nerve in my left shoulder also for me unable to use my left shoulder, and I am taking pain killer ever since release from the hospital which The doctor recently told me, I should'nt be taking pain killer because of the Condition of my esophageal.

I would appreciate if you could please initiate help from a civil Attorney to file a Civil action on my behalf because right at this moment I cannot eat Solid food because of the constant pain killer I am still taking in order to reduce the pain in my left shoulder.

Please find a copy of the previous procedure also a article of the working nurses environment and neccessary equipment to perform Their work currently occuring in Jamaica W.I.

Thank You

c/m

Respectfully Submitted
Devon Malcolm

Nurses fed up with working environment

SHOTS ARE being fired at the Kingston Public Hospital. This time, it's from the nurses.

Nurses from the KPH and Victoria Jubilee hospitals - which are on the same compound - said not only do they feel unsafe, but they are tired of working without resources.

According to one nurse at the Victoria Jubilee Hospital, "We don't even have a staff bus for the persons who work the late shift. We are just fed up and frustrated. We have written so many letters to the different departments and nothing is being done," she said.

Another nurse, who wished not to be named, said, they were often without the necessary equipment to do their work. "Sometimes we don't even have pen and paper, and that is not the bad part. There are times when the operating theatre cannot be used because there is no oxygen flow metre, urine bag and suture. That cannot be ..."

Security problem

She said the absence of a staff bus posed a security problem for the workers. She highlighted the shooting of David Duncan, a man who was shot outside KPH recently. According to police reports, Duncan, 42, was at his stall at the corner of North and Princess streets when shots were heard, and upon investigations, he was found dead.

"There are so many instances of our nurses going home in the nights and they are robbed, especially around pay day time ... The other night, one of our nurses, as soon as she stepped outside the gate, she saw the man get shot. We can't take anymore," she said.

Duncan is the fourth person to be shot outside the hospital in six months. The others include two other vendors and a hospital worker.

According to an officer at the police post located on the hospital's compound, they have not increased any of their security measures in the wake of the frequent shootings. "We are responsible for what happens on the compound, and none of the shootings have occurred on the hospital compound."

Kavelle Anglin-Christie

NEW YORK DOWNTOWN HOSPITAL
170 WILLIAM STREET
NEW YORK, NEW YORK 10038
212-263-7102

Date: 04-25-2005 ***Name:*** Malcolm Devon

MR#: 7271857 ***DOB:*** 02-01-1965

Date of the procedure: April 25, 2005.

Preoperative diagnosis: Esophageal achalasia, status post pneumatic dilatation x 2.

Postoperative diagnosis: Esophageal achalasia, status post pneumatic dilatation x 2.

Procedure: Bronchoscopy, left thoracotomy, esophageal dilatation with a #50 French Bougie dilator, esophageal myotomy, and Dor anterior fundoplication.

Surgeon: Michael D. Zervos, M.D.

First assistant: Manny Molina, M.D.

History: This is a 40-year-old male who is a federal prisoner who has a history of esophageal achalasia and dysphagia. He had an esophagogram performed, which is consistent with his diagnosis, and an endoscopy with failed pneumatic dilatation x 2. The patient was referred by Dr. Forrest Manheimer for this reason. The risks, benefits, and alternatives of the procedure were discussed with the patient who is accompanied by his officers at the time. The risks including intraoperative myocardial infarction, renal failure, respiratory failure, bleeding, infection, and death were all mentioned.

The patient's history as noted earlier, the patient is a 40-year-old male with a longstanding history of esophageal achalasia with mainly dysphagia to solids, but could eat most liquids and pureed food. The patient had undergone pneumatic dilatation twice and had recurrent symptoms after this treatment. The patient was referred for an esophageal myotomy. The risks were explained to the patient and include esophageal preparation, sepsis, mediastinitis, bleeding, multiorgan failure, and death.

Procedure: The patient entered the Operating room, was placed in the supine position. Adequate hemodynamic monitoring was achieved via electrocardiogram. Right radial arteria line

was placed. Peripheral venous access was established. The area of the left chest was prepped and draped in the usual sterile fashion. A double lumen endotracheal tube was positioned. A bronchoscopy performed at this time did not reveal any endobronchial pathology. The tube was secured. The patient was positioned with the left chest up in the right lateral decubitus. An axillary roll was placed. All pressure points were padded and secured. The area of the left chest was prepped and draped in the usual sterile fashion. Betadine and sterile drapes were used. A seventh interspace lateral thoracotomy was performed. The latissimus was divided. The serratus was spared. Entry into the pleural space was then gained. The inferior pulmonary ligament was divided and the lung was isolated and retracted out of the way. The esophagus was encircled with Penrose drain and mobilized from the level of the diaphragmatic hiatus up to the level of the inferior pulmonary ligament. The esophagus was very dilated and strictured down to the level of stump. This was a typical appearance of achalasia esophagus. The hiatus was enlarged from the pleural space and the fundus of the stomach was partially delivered into the chest in this manner. This gave us a clear view of the GE junction and the anterior portion of the stomach. A myotomy was performed over the strictured area for approximately an area of about 10 cm and the muscular layer was separated utilizing #15 blade and a tonsil initially, and once into the correct plane, the muscular layer of the esophagus with the strictured area was split with electrocautery. The myotomy was performed on to the stomach for approximately 1 cm. Upon completion of the myotomy, the anterior portion of the fundus of the stomach was mobilized anterior to the stomach and was tacked down to the muscular layer of the esophagus revealing a partial anterior wrap as described by the Dor procedure anterior fundoplication. A pleural tube was placed into the left chest. This was secured with a heavy-braided silk suture and umbilical tape. The lung was re-inflated. Thoracotomy was re-approximated with #2 pericostal sutures and the incision was closed in two layers of 0 Vicryl followed by 2-0 Vicryl and 3-0 Monocryl on the skin.

Michael D. Zervos, M.D.
Assistant Professor of Surgery

cc: Forrest Manheimer, M.D.